

**DEVEAUX DENTAL CARE CENTER
PATIENT INFORMATION**

Today's Date: _____

www.drdeveaux.com

Patient's Name _____ Male / Female
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____ E-Mail _____

Please fill out the subscriber information located in the box below

How did you hear about us? _____

SUBSCRIBER / RESPONSIBLE PARTY INFORMATION

Parent or Guardian (Person responsible for account) _____
Last First Middle

Address _____
Street City State Zip

Relationship to Patient _____ SSN# _____ DOB: _____

Employer Name _____ Employer Phone Number _____

Employer Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Driver's License Number _____

INSURANCE INFORMATION

Subscriber's Name _____ Subscriber's SSN# _____
Insurance Company Name _____ Group No. _____

Do you have dual Coverage? Yes No If yes:

Subscriber's Name _____ Subscriber's SSN# _____
Insurance Company Name _____ Group No. _____

PAYMENT OPTIONS FOR OUR PATIENTS

Our mission is to deliver the finest, most cost effective health care treatment available today. Following your doctor's diagnosis, the financial coordinator will advise you of their plan for treatment. Additionally, we will discuss with you the cost of today's and future treatments. Payments (for today's visit and your future visits) are due at time of treatment. However, we will gladly file any Dental Insurance that you carry, but will ask for your co-pay on the same day of your visit. We do offer several alternative payments programs for your convenience.

Please indicate below the form of payment you wish to use to settle your account:

- _____ 1. Cash or Check.
- _____ 2. MasterCard, Visa, American Express and Discover.
- _____ 3. Care Credit – If you choose this option, please request and complete the Care Credit Application.

I authorize the use of my signature to be used for all insurance claims, release of information to insurance companies, doctor and staff to act as my agents in helping me obtain payment from my insurance company. I also authorize payment directly to my doctor. This original will be placed in my file. **I understand that if my insurance(s) company has not paid in 45 days, I agree to pay in full. I also understand that I am financially responsible for my fees regardless if my insurance carrier pays or not.**

Signature of Patient or Responsible Party Date